

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3202 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 03/15/2011 |
| NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MORRISTOWN | | | STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST ECONOMY ROAD MORRISTOWN, TN 37814 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| N 000 | Initial Comments During complaint investigation number TN00027661, conducted on March 14, 2011, at Life Care Center of Morristown, no deficiencies were cited in relation to the complaint under chapter 1200-8-6, Standards for Nursing Homes. | N 000 | | | |

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6000

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If continuation sheet 1 of 1